FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045252

Facility Name: Havana Health Care Center

Address: 609 N. Harpham (Number) Havana (City) 62644 (Zip Code)

County: Mason

Telephone Number: (309) 543-6121 **Fax #** (309) 543-1233

IDPA ID Number: 371346306008

Date of Initial License for Current Owners: 03/01/01

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[x]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,938	1,938	8
9	SNF/PED					9
10	ICF	20,233	5,803		26,036	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,233	5,803	1,938	27,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.21%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 03/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,938

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	104,776	11,829		116,605		116,605		116,605			1
2	Food Purchase		107,157		107,157		107,157		107,157			2
3	Housekeeping	75,095	10,538		85,633		85,633		85,633			3
4	Laundry	35,239	8,507		43,746		43,746		43,746			4
5	Heat and Other Utilities			76,945	76,945		76,945	470	77,415			5
6	Maintenance	36,296	27,438	4,692	68,426		68,426	839	69,265			6
7	Other (specify):*											7
8	**TOTAL General Services**	251,406	165,469	81,637	498,512		498,512	1,309	499,821			8
	B. Health Care and Programs											
9	Medical Director			13,400	13,400		13,400		13,400			9
10	Nursing and Medical Records	848,982	59,828	600	909,410		909,410		909,410			10
10a	Therapy	70,203		150	70,353		70,353		70,353			10a
11	Activities	32,637	942	1,279	34,858		34,858		34,858			11
12	Social Services	21,344	359	1,279	22,982		22,982		22,982			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	973,166	61,129	16,708	1,051,003		1,051,003		1,051,003			16
	C. General Administration											
17	Administrative	129,152		24,913	154,065		154,065	(24,913)	129,152			17
18	Directors Fees											18
19	Professional Services			22,718	22,718		22,718	10,300	33,018			19
20	Dues, Fees, Subscriptions & Promotions			4,731	4,731		4,731	630	5,361			20
21	Clerical & General Office Expenses	53,704	4,552	13,865	72,121		72,121	14,136	86,257			21
22	Employee Benefits & Payroll Taxes			213,716	213,716		213,716	16,125	229,841			22
23	Inservice Training & Education			4,157	4,157		4,157	523	4,680			23
24	Travel and Seminar			10,323	10,323		10,323	1,318	11,641			24
25	Other Admin. Staff Transportation			1,201	1,201		1,201	1,238	2,439			25
26	Insurance-Prop.Liab.Malpractice			42,235	42,235		42,235	1,897	44,132			26
27	Other (specify):*											27
28	**TOTAL General Administration**	182,856	4,552	337,859	525,267		525,267	21,254	546,521			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,407,428	231,150	436,204	2,074,782		2,074,782	22,563	2,097,345			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Havana Health Care Center #0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			130,372	130,372		130,372	(31,700)	98,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,892	182,892		182,892	7,256	190,148			32
33	Real Estate Taxes			68,350	68,350		68,350		68,350			33
34	Rent-Facility & Grounds							2,817	2,817			34
35	Rent-Equipment & Vehicles			13,641	13,641		13,641	428	14,069			35
36	Other (specify):*											36
37	**TOTAL Ownership**			395,255	395,255		395,255	(21,199)	374,056			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,381		41,381		41,381		41,381			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* Nonallowable Costs			44,299	44,299		44,299	(44,299)				43
44	**TOTAL Special Cost Centers**		41,381	97,954	139,335		139,335	(44,299)	95,036			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,407,428	272,531	929,413	2,609,372		2,609,372	(42,935)	2,566,437			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,312)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,983)	43		8
9	Non-Straightline Depreciation	(38,936)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(296)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,585)	43		24
25	Fund Raising, Advertising and Promotional	(5,800)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg5A	(26,323)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (83,235)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	40,300		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 40,300		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (42,935)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Havana Health Care Center

ID# 0045252

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To disallow Lab expenses	$ (21,954)	43	1
2	To disallow Resident flowers	(443)	43	2
3	To disallow non-allowable X-rays	(3,926)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,323)		49

See Accountant's Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Havana Health Care Center **#** 0045252 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	470	0	0	0	0	0	0	0	0	0	470	5
6	Maintenance	0	839	0	0	0	0	0	0	0	0	0	839	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	1,309	0	0	0	0	0	0	0	0	0	1,309	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(24,913)	0	0	0	0	0	0	0	0	0	(24,913)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,300	0	0	0	0	0	0	0	0	0	10,300	19
20	Fees, Subscriptions & Promotions	0	630	0	0	0	0	0	0	0	0	0	630	20
21	Clerical & General Office Expenses	0	14,136	0	0	0	0	0	0	0	0	0	14,136	21
22	Employee Benefits & Payroll Taxes	0	16,125	0	0	0	0	0	0	0	0	0	16,125	22
23	Inservice Training & Education	0	523	0	0	0	0	0	0	0	0	0	523	23
24	Travel and Seminar	0	1,318	0	0	0	0	0	0	0	0	0	1,318	24
25	Other Admin. Staff Transportation	0	1,238	0	0	0	0	0	0	0	0	0	1,238	25
26	Insurance-Prop.Liab.Malpractice	0	1,897	0	0	0	0	0	0	0	0	0	1,897	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	21,254	0	0	0	0	0	0	0	0	0	21,254	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	22,563	0	0	0	0	0	0	0	0	0	22,563	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Havana Health Care Center # 0045252 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(38,936)	7,236	0	0	0	0	0	0	0	0	0	(31,700)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	7,256	0	0	0	0	0	0	0	0	0	7,256	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,817	0	0	0	0	0	0	0	0	2,817	34
35	Rent-Equipment & Vehicles	0	0	428	0	0	0	0	0	0	0	0	428	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,936)	14,492	3,245	0	0	0	0	0	0	0	0	(21,199)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(44,299)	0	0	0	0	0	0	0	0	0	0	(44,299)	43
44	**TOTAL Special Cost Centers**	(44,299)	0	0	0	0	0	0	0	0	0	0	(44,299)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(83,235)	37,055	3,245	0	0	0	0	0	0	0	0	(42,935)	45

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	See Sch. 6A					
Mark Petersen	See Sch. 6A	See Attached Schedule 6A			See Attached Schedule 6A	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Petersen Health Care, Inc.	0.00%	$ 470	$ 470	1
2	V	6	Maintenance		Petersen Health Care, Inc.	0.00%	839	839	2
3	V	17	Administrative	24,913	Petersen Health Care, Inc.	0.00%		(24,913)	3
4	V	19	Professional Services		Petersen Health Care, Inc.	0.00%	10,300	10,300	4
5	V	20	Dues, Fees, & Subscriptions		Petersen Health Care, Inc.	0.00%	630	630	5
6	V	21	Clerical & General Office		Petersen Health Care, Inc.	0.00%	14,136	14,136	6
7	V	22	Employee Benefits		Petersen Health Care, Inc.	0.00%	16,125	16,125	7
8	V	23	Inservice Training		Petersen Health Care, Inc.	0.00%	523	523	8
9	V	24	Travel & Seminar		Petersen Health Care, Inc.	0.00%	1,318	1,318	9
10	V	25	Other Admin Staff Transport.		Petersen Health Care, Inc.	0.00%	1,238	1,238	10
11	V	26	Insurance		Petersen Health Care, Inc.	0.00%	1,897	1,897	11
12	V	30	Depreciation		Petersen Health Care, Inc.	0.00%	7,236	7,236	12
13	V	32	Interest		Petersen Health Care, Inc.	0.00%	7,256	7,256	13
14	Total			$ 24,913			$ 61,968	$ * 37,055	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent-Facility & Grounds	$	Petersen Health Care, Inc.	0.00%	$ 2,817	$ 2,817	15
16	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	0.00%	428	428	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,245	$ * 3,245	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center
Provider # 0045252
12/31/2002

Schedule 6A

VII Related Parties-Page 6

Related Nursing Homes	City	Ownership %	1/1-8/30/02	8/31-12/31/02
Robings Manor Nursing Home	Brighton, IL	James Petersen	60%	0%
Countryview Terrace	Louisville, IL	Mark Petersen	40%	100%
Sunset Manor Nursing Home	Canton, IL			
Kewanee Care Home	Kewanee, IL			
Arcola Health Care Center	Arcola, IL			
Eastview Terrace	Sullivan, IL			
Havana Health Care Center	Havana, IL			
Palm Terrace of Mattoon	Mattoon, IL			
Bement Health Care Center	Bement, IL			
Prairie City Health Care Center	Prairie City, IL *			

Out of State Nursing Homes

* Not affiliated after 8/30/02

Meadow Lawn Nursing Center	Davenport, IA
Friendly Village	Rhinelander, WI *
Horizons Unlimited	Rhinelander, WI *
Taylor Park	Rhinelander, WI *
Passport	Rhinelander, WI *
Cumberland Heights-Tomahawk	Tomahawk, WI *
Maple Park	Rhinelander, WI *
Opportunities Unlimited (Workshop setup, no beds)	

Related Assisted Living

Courtyard Estates	Kewanee, IL

Other Related Business Entities

Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping
Petersen Property	Canton, IL Building-Sunset Manor

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Petersen	Ex-President	Administrative	Sched. 6A	294,153	6	12.00	Salary	$ 40,847	L17, C1	1
2	Mark Petersen	President	Administrative	Sched. 6A	109,758	6	12.00	Salary	15,242	L17, C1	2
3	Mark Petersen	Administrative	Administrative	Sched. 6A	110,637	6	12.00	Salary	15,363	L17, C1	3
4	Todd Petersen	Administrative	Administrative	Sched. 6A	59,745	6	12.00	Salary	8,297	L21 C1	4
5											5
6											6
7											7
8			See attached Schedule 7A								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 79,749		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Havana Health Care Center, Inc
Provider # 0045252
12/31/2002

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Palm Terrace	Arcola Health Care	Kewanee Care Center	Bement Health Care	Country View Terrace	Eastview Terrace	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Prairie City	Total	Havana Care Center	Grand Total
James Petersen	5,410	50,451	39,308	29,605	8,487	29,671	33,470	34,462	54,493	8,796	294,153	40,847	335,000
Mark Petersen	2,018	18,825	14,668	11,047	3,166	11,071	12,489	12,859	20,333	3,282	109,758	15,242	125,000
Mark Petersen-administrative	2,034	18,976	14,785	11,135	3,192	11,160	12,589	12,962	20,496	3,308	110,637	15,363	126,000
Todd Petersen	1,097	10,247	7,984	6,013	1,724	6,027	6,798	7,000	11,068	1,787	59,745	8,297	68,042
Total Compensation Received From Other Nursing Homes	10,559	98,499	76,745	57,800	16,569	57,929	65,346	67,283	106,390	17,173	574,293	79,749	654,042

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	229,422	11	$ 3,858	$	27,974	$ 470	1
2	6	Maintenance	Patient Days	229,422	11	6,877		27,974	839	2
3	19	Professional Services	Patient Days	229,422	11	84,471		27,974	10,300	3
4	20	Dues, Fees & Subscriptions	Patient Days	229,422	11	5,163		27,974	630	4
5	21	Clerical & General Office	Patient Days	229,422	11	115,931		27,974	14,136	5
6	22	Employee Benefits	Patient Days	229,422	11	132,243		27,974	16,125	6
7	23	Inservice Training	Patient Days	229,422	11	4,287		27,974	523	7
8	24	Travel & Seminar	Patient Days	229,422	11	10,813		27,974	1,318	8
9	25	Other Admin Staff Transport.	Patient Days	229,422	11	10,154		27,974	1,238	9
10	26	Insurance	Patient Days	229,422	11	15,558		27,974	1,897	10
11	30	Depreciation	Patient Days	229,422	11	59,343		27,974	7,236	11
12	32	Interest	Patient Days	229,422	11	59,511		27,974	7,256	12
13	34	Rent-Facility & Grounds	Patient Days	229,422	11	23,100		27,974	2,817	13
14	35	Rent-Equipment & Vehicles	Patient Days	229,422	11	3,511		27,974	428	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 534,820	$		$ 65,213	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	$3,179.00	08/31/02	$ 2,935,484	$ 2,922,766	08/01/07	varies	$ 164,636	1
2	Bank of Farmington		X	Van	$1,126.00	03/28/01	54,060	30,409	04/27/05	0.0750	1,871	2
3	Bank of Farmington		X	Car	$585.00	05/30/01	14,030	2,923	06/29/03	0.0750	519	3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Line of Credit	Interest	08/31/02	254,682	254,682	08/31/03	varies	15,524	6
7												7
8												8
9	TOTAL Facility Related				$4,890.00		$ 3,258,256	$ 3,210,780			$ 182,550	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			342	10
11								Allocated from Management Co.			7,256	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,598	14
15	TOTALS (line 9+line14)						$ 3,258,256	$ 3,210,780			$ 190,148	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 63,650	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 65,743	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,093	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 65,743	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Amount paid by Prior Owners**	(514)	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 68,350	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000	63,650	11
2001	65,743	12

Real Estate tax accrual is 100% of prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0045252

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	005-3910000	Facility	$ 17.48	$ 17.48
2.	005-1479000	Facility	$ 65,725.76	$ 65,725.76
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,743.24	$ 65,743.24

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	418,945	2001	$ 200,000	1
2					2
3	TOTALS	418,945		$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2001	1971	$ 1,314,000	$ 33,692	35	$ 37,543	$ 3,851	$ 56,314	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			2001	22,650	581	20	1,133	552	1,699	9
10	Flooring			2001	5,890	151	20	295	144	442	10
11	Landscaping			2001	8,984	853	20	449	(404)	674	11
12	A/C Heating Unit			2001	3,695		20	185	185	277	12
13	Fencing			2002	758	12	20	19	7	19	13
14	Roofing			2002	500	7	20	13	6	13	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,356,477	$ 35,296		$ 39,637	$ 4,341	$ 59,438	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 264,630	$ 65,145	$ 37,803	$ (27,342)	7	$ 56,163	71
72	Current Year Purchases	29,166	10,869	2,083	(8,786)	7	2,083	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.		7,236	7,236				74
75	TOTALS	$ 293,796	$ 83,250	$ 47,122	$ (36,128)		$ 58,246	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge Caravan	2001	$ 46,577	$ 14,905	$ 9,315	$ (5,590)	5	$ 13,973	76
77	Facility Use	1999 Oldsmobile	2001	12,992	4,157	2,598	(1,559)	5	3,898	77
78										78
79										79
80	TOTALS			$ 59,569	$ 19,062	$ 11,913	$ (7,149)		$ 17,871	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,909,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,608	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 98,672	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (38,936)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 135,555	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Management Co.				2,817			6
7	TOTAL				$ 2,817 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 14,069 Description: Oxygen tanks $9,714 ; Copy Machine $3,043 ; Postage Meter $884 ; Allocated from Management Co. $428
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A, C1	2080	hrs	$ 34,515		$	$	2,080	$ 34,515	1
2	Licensed Speech and Language Development Therapist	L10A, C1	187	hrs	5,862				187	5,862	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A, C1	1377	hrs	29,826				1,377	29,826	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39, C2		# of prescrpts				41,381		41,381	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 70,203		$	$ 41,381	3,644	$ 111,584	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 118,535	$ 118,535	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,411,110	1,411,110	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,061	72,061	6
7	Other Prepaid Expenses	8,644	8,644	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,610,350	$ 1,610,350	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,356,477	1,356,477	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	353,365	353,365	16
17	Accumulated Depreciation (book methods)	(210,061)	(135,555)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,699,781	$ 1,774,287	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,310,131	$ 3,384,637	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 238,707	$ 238,707	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	254,682	254,682	29
30	Accrued Salaries Payable	55,082	55,082	30
31	Accrued Taxes Payable (excluding real estate taxes)	53	53	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,743	65,743	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Interest	53,889	53,889	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 668,156	$ 668,156	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,956,098	2,956,098	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,956,098	$ 2,956,098	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,624,254	$ 3,624,254	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (314,123)	$ (239,617)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,310,131	$ 3,384,637	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (72,475)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (72,475)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	238,402	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(480,050)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (241,648)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (314,123)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,780,246	1
2	Discounts and Allowances for all Levels	3,103	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,783,349	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	61,402	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 61,402	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,596	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,596	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	1,427	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,427	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,847,774	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	498,512	31
32	Health Care	1,051,003	32
33	General Administration	525,267	33
	B. Capital Expense		
34	Ownership	395,255	34
	C. Ancillary Expense		
35	Special Cost Centers	85,680	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,609,372	40
41	**Income before Income Taxes (line 30 minus line 40)****	238,402	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 238,402	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Entity is a cash basis tax payer.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Havana Health Care Center
Provider # 0045252
12/31/2002

Schedule 19A

XVII. INCOME STATEMENT (continued)

E. Other Revenue

Vending Machine Income	$	350
Transportation Income	$	98
Miscellaneous Income		979
Total	**$**	**1,427**

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,907	1,907	$ 44,000	$ 23.07	1
2	Assistant Director of Nursing	607	607	11,800	19.44	2
3	Registered Nurses	5,492	5,492	99,871	18.18	3
4	Licensed Practical Nurses	14,813	14,813	238,842	16.12	4
5	Nurse Aides & Orderlies	42,224	42,224	427,401	10.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,644	3,644	70,203	19.27	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,060	2,060	22,043	10.70	9
10	Activity Assistants	1,507	1,507	10,594	7.03	10
11	Social Service Workers	2,080	2,080	21,344	10.26	11
12	Dietician					12
13	Food Service Supervisor	2,291	2,291	25,539	11.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,376	11,376	79,237	6.97	15
16	Dishwashers					16
17	Maintenance Workers	2,545	2,545	36,296	14.26	17
18	Housekeepers	10,112	10,112	75,095	7.43	18
19	Laundry	4,828	4,828	35,239	7.30	19
20	Administrator	2,482	2,482	129,152	52.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,658	3,663	53,704	14.66	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	906	906	10,667	11.77	31
32	Other Health Ca Care Plan Coord.	953	953	16,401	17.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,485	113,490	$ 1,407,428 *	$ 12.40	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L10, C3	39
40	Physical Therapy Consultant	2	150	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,279	L11, C3	44
45	Social Service Consultant	25	1,279	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	52	$ 16,708		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Showalter	Administrative	0	$ 57,700
James Petersen	Administrative	Sched 6A	40,847
Mark Petersen	Administrative	Sched 6A	30,605
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 129,152

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 24,913
TOTAL (agree to Schedule V, line 17, col. 3)	$ 24,913
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin		$
& Glasser LLP	Accounting	6,300
Ginoli & Company	Accounting	4,229
ADP	Computer	7,786
Ivans	Computer	344
LTC Solutions	Computer	2,403
Miscellaneous	Computer	583
Bush & Snyder Assoc.	Legal	1,073
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,718

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,764
Unemployment Compensation Insurance	15,250
FICA Taxes	96,148
Employee Health Insurance	60,038
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401-K Management Fee	1,934
Employee Relations	5,582
Allocated from Management Co.	16,125
TOTAL (agree to Schedule V, line 22, col.8)	$ 229,841

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 105
Advertising: Employee Recruitment	648
Health Care Worker Background Check	122
(Indicate # of checks performed 10)	
Illinois Health Care Association dues	2,335
Various Licenses	310
Various Dues & Subscriptions	1,211
Allocated from Management Co.	630
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,361

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,008
Seminar Expense	315
Allocated from Management Co.	1,318
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,641

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center
Provider #: 0045252
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)		22,718
Allocated from Management Company	**Legal**	1,004
Allocated from Management Company	**Other**	9,296
Total (agree to Schedule V, line 19, column 8)		33,018

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0045252 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9								N/A					
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0045252 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N/A

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA $2,335

(3) Did the nursing home make political contributions or payments to a politica action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 519 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 53,655
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? No Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in Progress

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Havana Health Care Cen** **03:03 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-42,935	equal to	-42,935	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	190,148	equal to	190,148	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	68,350	equal to	68,350	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	98,672	equal to	98,672	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,817	equal to	2,817	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	14,069	equal to	14,069	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	70,203	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	70,353	equal to	70,353	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	41,381	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	498,512	equal to	498,512	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,051,003	equal to	1,051,003	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	525,267	equal to	525,267	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	395,255	equal to	395,255	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	85,680	equal to	85,680	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	53,655	equal to	53,655	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	832,581	equal to	848,982	-16,401	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	70,203	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	32,637	equal to	32,637	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	21,344	equal to	21,344	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	104,776	equal to	104,776	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,296	equal to	36,296	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	75,095	equal to	75,095	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	35,239	equal to	35,239	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	129,152	equal to	129,152	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	53,704	equal to	53,704	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,407,428	equal to	1,407,428	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	13,400	< or = to	13,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	600	< or = to	600	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,279	< or = to	1,279	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,279	< or = to	1,279	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	129,152	equal to	129,152	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	24,913	equal to	24,913	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	22,718	equal to	22,718	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	229,841	equal to	229,841	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,361	equal to	5,361	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	11,641	equal to	11,641	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	53,655	equal to	53,655	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	16,125	-16,125	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,938	equal to	1,938	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	40,300	equal to	40,300	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	3,210,780	equal to	3,210,780	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	65,743	equal to	65,743	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	200,000	equal to	200,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,356,477	equal to	1,356,477	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	353,365	equal to	353,365	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	135,555	equal to	135,555	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-314,123	equal to	-314,123	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	238,402	equal to	238,402	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,310,131	equal to	3,310,131	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	104,776	11,829	0	116,605	0	116,605	0	116,605
2. Food P	0	107,157	0	107,157	0	107,157	0	107,157
3. Housek	75,095	10,538	0	85,633	0	85,633	0	85,633
4. Laundry	35,239	8,507	0	43,746	0	43,746	0	43,746
5. Heat ar	0	0	76,945	76,945	0	76,945	470	77,415
6. Mainter	36,296	27,438	4,692	68,426	0	68,426	839	69,265
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	251,406	165,469	81,637	498,512	0	498,512	1,309	499,821
9. Medical	0	0	13,400	13,400	0	13,400	0	13,400
10. Nursin	848,982	59,828	600	909,410	0	909,410	0	909,410
10a. Ther	70,203	0	150	70,353	0	70,353	0	70,353
11. Activit	32,637	942	1,279	34,858	0	34,858	0	34,858
12. Social	21,344	359	1,279	22,982	0	22,982	0	22,982
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	973,166	61,129	16,708	1,051,003	0	1,051,003	0	1,051,003
17. Admin	129,152	0	24,913	154,065	0	154,065	-24,913	129,152
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	22,718	22,718	0	22,718	10,300	33,018
20. Fees,	0	0	4,731	4,731	0	4,731	630	5,361
21. Clerica	53,704	4,552	13,865	72,121	0	72,121	14,136	86,257
22. Emplo	0	0	213,716	213,716	0	213,716	16,125	229,841
23. Inserv	0	0	4,157	4,157	0	4,157	523	4,680
24. Travel	0	0	10,323	10,323	0	10,323	1,318	11,641
25. Other	0	0	1,201	1,201	0	1,201	1,238	2,439
26. Insura	0	0	42,235	42,235	0	42,235	1,897	44,132
27. Other	0	0	0	0	0	0	0	0
28. Total (	182,856	4,552	337,859	525,267	0	525,267	21,254	546,521
29. Total (	1,407,428	231,150	436,204	2,074,782	0	2,074,782	22,563	2,097,345
30. Depre	0	0	130,372	130,372	0	130,372	-31,700	98,672
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	182,892	182,892	0	182,892	7,256	190,148
33. Real E	0	0	68,350	68,350	0	68,350	0	68,350
34. Rent -	0	0	0	0	0	0	2,817	2,817
35. Rent -	0	0	13,641	13,641	0	13,641	428	14,069
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	395,255	395,255	0	395,255	-21,199	374,056
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	41,381	0	41,381	0	41,381	0	41,381
40. Barber	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	53,655	53,655	0	53,655	0	53,655
43. Other	0	0	44,299	44,299	0	44,299	-44,299	0
44. Total S	0	41,381	97,954	139,335	0	139,335	-44,299	95,036
45. Grand	1,407,428	272,531	929,413	2,609,372	0	2,609,372	-42,935	2,566,437

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	118,535	118,535
2. Cash - F	0	0
3. Account	1,411,110	1,411,110
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	72,061	72,061
7. Other Pr	8,644	8,644
8. Account	0	0
9. Other (s	0	0
10. Total c	1,610,350	1,610,350
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	200,000	200,000
14. Buildin	1,356,477	1,356,477
15. Leaseh	0	0
16. Equipn	353,365	353,365
17. Accum	-210,061	-135,555
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	0	0
24. Total L	1,699,781	1,774,287
25. Total A	3,310,131	3,384,637
CURRENT LIABILITIES		
26. Accour	238,707	238,707
27. Officer'	0	0
28. Accour	0	0
29. Short-T	254,682	254,682
30. Accrue	55,082	55,082
31. Accrue	53	53
32. Accrue	65,743	65,743
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	53,889	53,889
37. Other (	0	0
38. Total C	668,156	668,156
LONG TERM LIABILITES		
39.Long-T	2,956,098	2,956,098
40.Mortga	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	2,956,098	2,956,098
46.Total Li	3,624,254	3,624,254
47.Total E	-314,123	-239,617
48.Total Li	3,310,131	3,384,637

		Balance per Medicaid Trial Balance
1.	Gross F	2,780,246
2.	Discour	3,103
	Subtota	2,783,349
4.	Day Ca	0
5.	Other C	0
6.	Therapy	61,402
7.	Oxygen	0
	Subtota	61,402
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Teleph	1,596
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	1,596
24.	Contril	0
25.	Interes	0
	Subtot-	
27.	Other	1,427
28.	Other	0
	Subtot	1,427
30.	Total F	2,847,774
31.	Gener	498,512
32.	Health	1,051,003
33.	Gener	525,267
34.	Owner	395,255
35.	Specia	85,680
35.	Provid	53,655
37.	Other	0
40.	Total E	2,609,372
41.	Incom	238,402
42.	Incom	0
43.	Net In	238,402

Page

Line 16 for mortgage insurance.